# NEWS

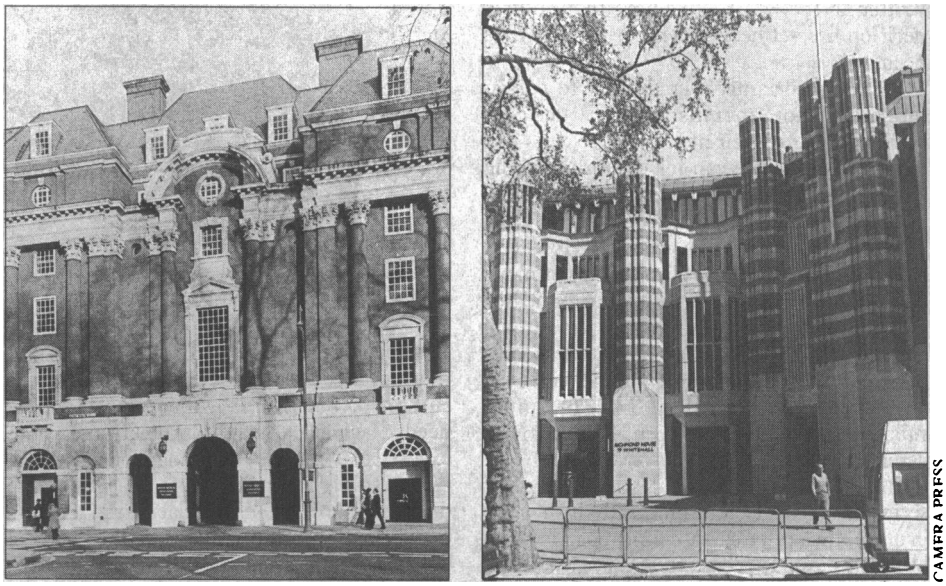
## BMA meets ministers on NHS review

In a week when three craft conferences made clear their opposition to many of the government's proposals for changing the NHS (p 1714) a BMA delegation met the Secretary of State, Mr Kenneth Clarke, to discuss the government's review. At a two hour meeting the chairman of the BMA's council, Dr John Marks, told Mr Clarke that while the association shared his aims for a better NHS it disagreed fundamentally with some of his means. In particular, the association objected to self governing hospitals and practice budgets as the profession could see no logic in the proposals or in the concept of introducing financial contracts. For his part, however, Mr Clarke saw these ideas as "crucial to delivering the better service which both I and the BMA want." Though the two sides agreed to disagree on these principles, they did agree to discuss them further.

The association pointed out, however, that the profession supported the introduction of medical audit, accepted the need for better information systems, and agreed in principle with the concept of money following patients across district boundaries. Further meetings will be held with ministers on these subjects as well as on the question of indicative drug budgets, which was not discussed because of lack of time.

In a comment to the *BMJ* Dr Marks emphasised the BMA's fundamental disagreement with the government on self governing hospitals, arguing that medical audit, better information systems, and a scheme for money to follow patients could all be introduced without legislation. So long as more funds were provided these changes would achieve more effective improvements with much less disruption than would the proposals in the NHS review. "I also told Mr Clarke," added the chairman of council, "that the BMA would continue its public campaign against the white paper at least until a new NHS act was on the statute book."

This week the BMA announced that the next stage of this campaign, which started with leaflets for patients and extensive newspaper advertising, would be a series of public meetings. To be held throughout the country starting in Bath on 22 June, these meetings are aimed at obtaining the public's views on the NHS white paper and stimulating debate on the future of the service. Other meetings planned so far will be held in Peterborough (27 June), Aldershot (28 June), and Aberystwyth (29 June).—GORDON MACPHERSON



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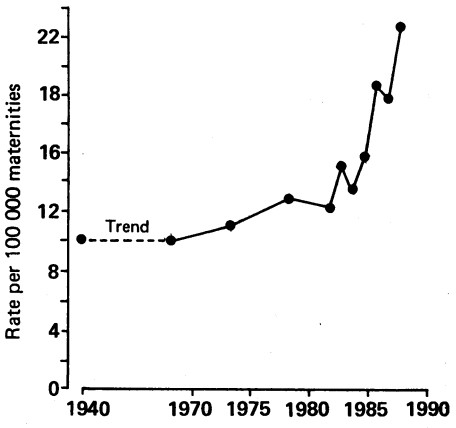
*Divided houses: the BMA and Department of Health differ over how to improve the NHS*

## More triplets than ever

In 1988, 157 sets of triplets, 12 sets of quadruplets, and one set of quintuplets were born in England and Wales. These figures, given in a written parliamentary reply to a question from Dafydd Wigley MP, represent the highest numbers of triplets and quadruplets since records began in 1939. After a gradual increase since 1980 triplets and higher order births increased sharply from 15·8 per 100 000 women giving birth in England and Wales in 1985 to 20·7 in 1986. Strangely, this was followed by a small decrease to 19·8 in 1987 and another sharp increase to 24·7 in 1988.

Such births pose many problems for health service staff, particularly in obstetric and neonatal units. For parents, though, there is the much longer term and often overwhelming task of caring for three or more babies simultaneously. The increase in multiple births is generally thought to result from increasing use of drugs to treat infertility and techniques for assisted reproduction. The extent to which this may be so is a question tackled in the study of triplet and higher order births, which followed up births in 1980 and 1982-5, and is also among the questions in the current survey of births in 1989 by the British Association of Perinatal Medicine.




*Source:* OPCS birth statistics, series FM1

*Triplet and higher order births, England and Wales 1940-89*

The study of triplet and higher order births is now being written up, but its steering committee is making a final appeal to general practitioners who have not yet returned questionnaires to it to do so urgently. If the forms have been mislaid new copies can be obtained by ringing 01 242 0262 ext 2221.

## Uncertainty over medical defence

Doctors who thought that they had seen the end of the year's confusion over insurance for professional liability were wrong, and any who have planned to let their insurance lapse need to act quickly to make sure they are covered. The premature reassurance came in March (*BMJ*, 1 April, p 852), when the health departments proposed that NHS

health authorities should take over financial liability for medical negligence by hospital doctors from 1 July. The BMA council accepted the proposals in principle (13 May, p 1320), subject to negotiation on details, and has posed several questions about the scheme (box). But only days before the new scheme was planned to come into effect Sir Donald Acheson, the chief medical officer, has written to the BMA explaining that no firm decision has yet been taken nor has any date been set.

So the uncertainty seems likely to persist for several more months as the parties concerned continue their negotiations.

What does this mean for doctors working in the NHS or outside it? They will certainly need to continue to be insured with one of the recognised medical defence bodies. However, from 1 April this year—for the first time—doctors have been able to shop around for the cheapest premium. The traditional gentleman's agreement among these bodies to agree a uniform subscription melted at the start of the year after differences on future subscription policies between the two major defence bodies.

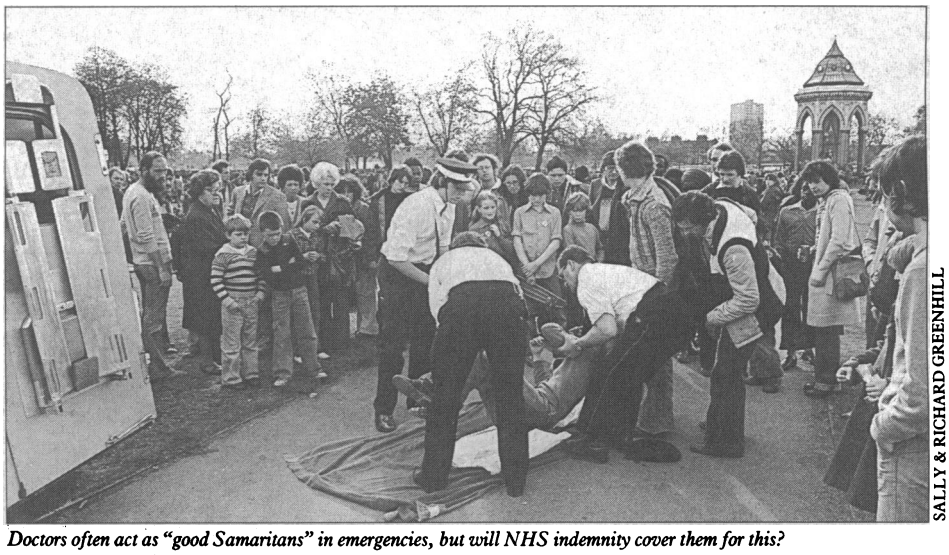
Hospital doctors may find that their subscriptions have risen dramatically if they are in one of the high risk specialties, particularly obstetrics. What is certain is that all doctors need some kind of cover—for even those no longer in practice will mostly want to feel safe if they treat someone in an emergency.

Exactly what has prolonged the negotiations is unclear as they have been confidential. Nevertheless, Sir Donald's letter does set out current thinking at the Department of Health. Firstly, he sees a major continuing role for the expert knowledge of the medical defence organisations. The department expects health authorities to be advised by the medical defence organisations on which claims should be contested and which should be settled out of court. Secondly, health authorities would take financial responsibility when they were legally liable. Thirdly, the department expects that doctors may wish to be separately represented in any defence allegations of negligence. Normally, this would be in agreement with the health authority. Safeguards would, however, be needed against a health authority incurring excess costs because of a doctor's insistence on pursuing a hopeless case. Fourthly, the discussion of the financial arrangements between the public sector and the medical defence organisations is looking at the substantial financial tail of contingent liabilities and how much of the reserves of the medical defence organisations relate to the hospital and community services. Subject to agreement between the parties the plan has been to transfer part of the reserves to the Department of Health, which claims that it intends that the medical defence organisations should be left with sufficient resources for them to be able to compete fairly for doctors not covered by the health authority indemnity. This may prove to be the most difficult part of the negotiations on introducing crown indemnity.

Finally, Sir Donald's letter spells out that though the proposed health authority indemnity would cover doctors and dentists when they were working for a health authority, there are many circumstances in which a doctor would not be covered. Most NHS hospital doctors will still need to take out a form of medical defence subscription. Future subscriptions for them should not need to be as high as at present because they would not need to cover the costs of the substantial damages that are now being awarded in some cases of medical negligence.

A decision by the government is needed extremely soon. Meanwhile, the present arrangements for partial reimbursement by health authorities of some hospital doctors' subscriptions end on 31 December this year.

—TONY SMITH



SALLY & RICHARD GREENHILL

*Doctors often act as "good Samaritans" in emergencies, but will NHS indemnity cover them for this?*

## Questions about crown indemnity

The BMA has asked the Department of Health for clarification of the proposed NHS indemnity scheme. Its questions include the following:

- If a health authority decides for financial reasons to settle a case out of court, but a doctor believes that the case should be contested, will it be possible to challenge the authority's decision before settlement is made?
- Will the professional autonomy of the doctor be preserved? The profession fears that NHS indemnity might lead management to try to limit doctors' activities contractually
- Will doctors retain the right to have their own lawyers present at any legal proceedings?
- Will steps be taken to ensure that financial pressures do not lead some health authorities to allocate medical negligence cases to lawyers who lack the considerable skill needed to handle such cases properly?
- Are health departments prepared to introduce centralised handling or monitoring of cases to ensure uniformity and maintain an overview?
- Will general practice trainees be covered by NHS indemnity or refunded their indemnity subscription during their vocational training year?
- Will doctors covered by NHS indemnity be protected in respect of "good Samaritan" acts too?
- Will NHS indemnity cover junior doctors on NHS contracts that rotate to private hospitals while they are working there?

# Defence not the best form of attack

Given the government's obsession with the cost of medical care, a recent study on the prevalence of defensive medicine must be causing concern (*Journal of the Medical Defence Union* 1989;Summer:40-3). With a definition of defensive medicine as "adopting procedures which are not for the benefit of the patient but safeguard against the possibility of the doctor being sued" 80% of the 160 specialists and general practitioners who responded to a postal questionnaire admitted that they occasionally (50%), frequently (27%), or always (5%) did unnecessary tests, gave unnecessary drugs, admitted patients to hospital unnecessarily, and carried out unnecessary operations. What this adds up to in terms of unnecessary cost to the health service, not to mention anxiety and risk to patients, is anyone's guess.

But if defensive medicine is not the way to stem the tide of medical negligence claims what is? To Arnold Simanowitz, director of the charity Action for Victims of Medical Accidents (AVMA), the answer is deceptively simple: raise standards of medical practice. In his view this could readily be achieved by closer monitoring of current practice, improved audit, open discussion of common errors and ways to avoid them, detailed analysis of action to take when mistakes do occur, and, above all, improved

accountability. His mandate for these suggestions comes from the cumulative experience of the charity in dealing with some 6000 people who have sought help either to lodge a formal complaint about their care or to sue for negligence, and the charity has built up an informal panel of solicitors who specialise in medical negligence. This conjures up familiar prejudices. "But AVMA is not a doctor bashing organisation," said Arnold Simanowitz when I spoke to him last week. "Its prime concern is to get a fair deal for patients. This does not happen if solicitors ignorant about medical practice are pitted against the experienced defence union lawyers. British solicitors do not make a killing from medical negligence cases. It's not like the United States, where they get paid on a contingency basis, which may be up to 50% of the settlement; they get only a fixed hourly rate, and by their standards this is low."

Despite a shoestring budget—clients are not charged for the advice that they receive although solicitors are—the charity is now concerned with over a third of all legal claims against the medical profession. It is thus in a good position to look critically at the present system, about which Arnold Simanowitz is scathing. "The complaints machinery with its five separate channels is needlessly complex. The delay in processing claims is a disgrace. Doctors need to appreciate that it is not money that most patients are after but an explanation, an apology, reassurance that those concerned will be called to account and steps taken to ensure that the same 'mistake' does not happen again. Doctors' defensive attitudes, platitudinous comments about 'things sometimes going wrong,' and reluctance to accept any liability—largely because the defence unions advise against it—incense patients."

One solution, he suggests, is to set up an independent body that doctors could turn to for advice after a medical mishap. Unlike the defence unions it could offer constructive advice unfettered by considering the financial implications of the case. But more than this, defensive medicine and most medical negligence claims could be avoided altogether, in his view, if doctors were prepared to set standards and take steps to ensure that they were adhered to. "It's not the lawyers who define good medical practice, it's doctors, and they should do so. It's sterile to reiterate that set rules stifle initiative. There is too much special pleading. Patients have a right to sue if things go wrong."

LAW SOCIETY GAZETTE/WINPENNY

*Arnold Simanowitz, director of Action for Victims of Medical Accidents*

One of the key problems is that doctors fail to realise that victims of medical accidents need more care; this is not being provided, and the charity is being deluged with calls. It is frustrated not just by a lack of resources to deal with them all but also by a lack of input from the medical profession. Doctors could help examine how the present handling of complaints might be changed, the cause of complaints, and the means of preventing them. To this end the charity wants to set up a group of interested doctors who are prepared to work with it to look at medical accidents from the patients' point of view.—TESSA RICHARDS

Those interested should contact Action for the Victims of Medical Accidents, Bank Chambers, 1 London Road, Forest Hill, London SE23 3TP (01 291 2793).

# Osteopoietin stimulates growth of bone

A research group at the surgical clinic of the University of Tübingen in Germany claims to have found a growth factor that stimulates the development of bone cells from indifferentiated stem cells, as Dr Henning Heumann, a coworker in the group, told a press conference.

Three years ago the group, led by Dr Karlheinz Schmidt, biochemist and professor of surgery, isolated a substance from bone tissue that in animals could induce bone growth at sites where normally bone is not present. Professor Schmidt calls the substance osteopoietin because of its analogy with erythropoietin, the growth factor concerned with red cell development. In the first experiments osteopoietin isolated from chicken bones was injected through a hole into the cavity of the humerus in live chickens. Two weeks later single foci of bone growth were observed, and four months later the cavity, which in birds is normally filled with air, was entirely occluded with bone tissue.

The first human experiment was in Dr Heumann, who had 10 mg human osteopoietin implanted in his calf muscle. After 24 days a small piece of cartilage in an advanced stage of ossification was surgically removed from the implantation site. During that time he felt "no pain other than from the stitch," no immunological reactions were detected, and his blood count remained normal.

During the past two and half years Dr Heumann has given human osteopoietin to 12 patients with cholesteatoma, a rare but aggressive disease in which tesselated epithelium invades the mastoid cavity and the petrosal bone behind the inner ear. When the keratinised epithelium is surgically removed a cavity remains, which epithelium often starts reinvading. Artificial implants are commonly rejected in this region. Minute amounts of osteopoietin were sufficient to induce growth of bone in the cavity and to fill it within a few weeks, and no relapse of the disease has occurred in any of the patients.

So far human osteopoietin can be extracted only from fresh human bone material, which the group obtains from amputated limbs from orthopaedic operations. The bone is cryogenised in fluid nitrogen and ground to powder in a mortar, and the calcium component is washed out with hydrochloric acid. The remaining cell free dry substance comprises mainly collagen and several proteins and polypeptides, most of which have not yet been purified or sequenced, but which should include osteopoietin.

Professor Schmidt is not yet sure whether his proposed growth factor is a single protein, a system of factors acting simultaneously, or a cascade of agents acting successively. He thinks of osteopoietin as a "morphogenetic complex," which can transform undifferentiated stem cells into osteoblasts and activate them. The undifferentiated stem cells may well be the same as those giving rise to blood cells, which, according to Professor Schmidt's theory, are not only present in bone marrow but may be ubiquitous in soft tissues.

For clinical use osteopoietin cannot be simply injected but needs to be fixed to a solid carrier, which may be porous calcium minerals or apatites formed as small pellets, which are later integrated into the growing bone tissue or lyophilised collagen tissue or gelatin sheets, which are then degraded or dissolved.

The obvious promise of osteopoietin is its potential benefit for orthopaedic surgery—from osteosynthesis to implantation of artificial joints and teeth and from reconstructive to plastic surgery. Until osteopoietin is purified, sequenced, and made commercially available, which Professor Schmidt estimates "will still take years," clinicians will have to rely on resources of human bone material. To the group's disappointment an industrial sponsor is not yet in sight.—HELMUT L KARCHER, *Munich*

# The up tempo MRC

The contrast between the first corporate plan of the Medical Research Council published in 1986 and the second one published last week is astounding. The first was churned out reluctantly in the most ugly of typefaces and was full of objections to underfunding whereas the second is full of colour, more plush than the NHS review, and stuffed with upbeat ideas. Whingeing has been abolished, and the new MRC is on its way to the stars or a cure for AIDS. But the document is by no means all showbiz: unlike the NHS review it contains solid ideas.

The council plans to continue to cover everything from basic science to health services research, but a strategy committee has been established. This committee will identify subjects for both development and retrenchment: starting projects is easy; it's stopping them that is difficult. The plan does not go as far as identifying subjects fit for

retrenchment, but it does list programmes set for increased investment. They include the clinical research initiative, mapping the human genome, protein engineering, cognitive science, AIDS, toxicology, and cell biology. The council also plans to exploit new research opportunities in magnetic resonance imaging and spectroscopy, the molecular biology of mental illness, clinical applications of molecular virology, and the development of new vaccines.

The clinical research initiative is to be built around the new National Centre for Clinical Research at Hammersmith, but clinical research will also be developed selectively in four or five other centres. The council needs £48·5m at 1988 prices spread over five to six years for the centre and plans to raise a fifth from private sources. Drug companies are, says the plan, very interested. The council also plans to increase its commitment to health services research, cooperating with the Department of Health and the Economic and Social Research Council as it does so. Part of the strategy is to develop an effective training programme for health services research.

Cooperation is a key theme in the plan, and the council plans to cooperate closely with the medical charities, industry, and international organisations. It plans to increase its income from sources other than its grant from the Department of Education and Science as fast as it can, and it grew from about £7m in 1984-5 to about £11m in 1987-8. Other important strategic decisions are to increase the amount spent on training; to develop assessment criteria, performance indicators, and evaluation techniques; and to pay more attention to parliamentary and public interests. This plan is an impressive step in that direction.—RICHARD SMITH

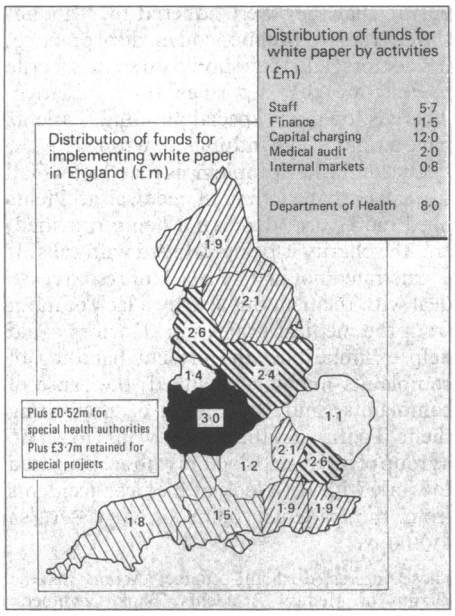
Copies of the corporate strategy 1989 are available from the Publications Group, MRC, 20 Park Crescent, London W1N 4AL.

# Money follows white paper

Last month Kenneth Clarke announced an additional £40m to help implement *Working for Patients*; this month Duncan Nicol, NHS chief executive, announced its distribution. The Department of Health will retain £8m to meet the costs of work on self governing hospitals and general practitioner practice budgets. The remaining £32m (less £3·7m retained centrally for specific regional projects) will be distributed to the 14 regions in England to fund initial work in five topics: staff, finance, capital charging, medical audit, and internal markets (box).

The figure of £40m was agreed in recent discussions with regional general managers, who estimated that this would be the cost of starting to implement the white paper this year. How the regional allocations, totalling £28·3m, will be spent at district level will be decided by individual regions.

The £5·7m allocation for staff aims at funding the first staff needed—especially in self governing hospitals—to take on devolved




and new functions such as industrial relations, managing consultant contracts, and determining pay. Extra money for finance will go towards training programmes and additional staff needed to design and implement treatment contracts. The costs of developing and maintaining a capital charges asset register also attracts additional funding of £12m, about £60 000 per health authority; £2m is allocated for coordinated development of medical audit across the country and £0·8m to fund additional posts in public health and health economics.

This additional money comes in advance of legislation implied by the white paper's proposals and, furthermore, in advance of detailed work necessary to implement the proposals. For example, a paper from the Department of Health explaining in more detail how the capital charging system is to work has not yet been published even though it was promised for May. Although health authorities have welcomed the extra cash, problems may arise in spending it; the Institute of Chartered Accountants of Scotland, for example, has recently told the Scottish Office that there may be shortages of skilled financial staff to implement some of the proposals.—JOHN APPLEBY

# Cuts in New Zealand

The health service in New Zealand is facing major financial problems. These are most severe in Auckland, where the health board—the largest in the country—has been sacked by the Minister of Health and replaced by a commissioner, who has the job of eliminating a budget deficit of $NZ46m (£17m).

The commissioner's proposals, announced on 17 May, include a programme of closures affecting two main hospitals (one psychiatric, the other maternity), three outlying maternity hospitals, and a geriatric unit. In addition, some acute services are to be relocated, day surgery is to be expanded as surgical beds are reduced, and assessment and rehabilitation services are to expand to help decrease the use of inpatient services. The commissioner has also proposed major savings in expenditure on support services, and he outlined plans to generate income through charging for car parking and selling blood products to private hospitals.

Several health boards confront a similar situation, albeit on a smaller scale. Behind the financial problems that have arisen recently is a history of poor management and latent tension between the Minister of Health and health boards. As locally elected bodies the boards see their principal duty as looking after the needs of their communities. Yet all of their money comes from national government, and they are not in a position to raise additional funds to meet what they perceive to be in the community's interest. The boards are therefore reluctant to take unpopular decisions even if this leads to overspending. The consequence in Auckland has been an accumulating deficit and a failure to make the changes necessary to keep within budget.

Faced with this situation the minister had little alternative but to suspend the board. At the same time the management of the health service is being strengthened through the appointment of general managers. In Auckland David King, currently district general manager of Exeter Health Authority, takes up a post in July with responsibility for implementing the reform package. And echoing Mrs Thatcher's proposals for the NHS, the health minister is seeking to change the composition of health boards by appointing more members with business and management experience.

Among hospital doctors there is increasing interest in resource management and the appointment of clinical directors. The Guy's model has received considerable publicity, and many doctors and managers believe that much of its approach is relevant to New Zealand. Nurses already play a key part in hospital management and see themselves as strong candidates for clinical director posts. In the longer term securing more effective participation by doctors and nurses in management is viewed as vital to the success of attempts to achieve higher levels of efficiency in the health service.

In one crucial respect New Zealand thinking has influenced developments in the NHS. This concerns the Gibbs report, *Unshackling the Hospitals*, which proposed a model of competition in the health service remarkably similar to that set out in *Working for Patients*. The irony is that its recommendations were rejected by the Labour government even though its advocacy of health boards as purchasers of care from competing providers has been taken up in a limited way in some places.

In place of competition the government is pushing ahead with modifications to the existing system. These incremental reforms are seen as preferable to a more market oriented health service. There is some amusement that the United Kingdom has opted for a model viewed by many informed observers within New Zealand as idiosyncratic.

One of the objectives of the Gibbs report was to increase the role of the private sector

in health service provision, and this is already happening in response to the funding problems of the public sector. Southern Cross, the main player in the private insurance and provision market, has announced plans to expand its activities. The chief executive of Southern Cross sees the private sector taking a bigger share of the future market, albeit in support of the public sector.

If next year's election sees the return of the National party the Gibbs prescription is likely to be embraced with greater enthusiasm in government. And by then, experience within the NHS may indicate whether the competitive route is worth taking. Always assuming, of course, that there is enough support for self governing hospitals and general practitioner budgets at least to give the ideas a try.—CHRIS HAM, *King's Fund Institute*

# Planning for disasters

At a symposium on the medical response to major disasters at the University of Keele's School of Postgraduate Medicine and Biological Sciences delegates heard repeatedly of the poor planning—or poor execution of plans—that has been the hallmark of recent disasters in Britain and overseas, thus diminishing the effectiveness of emergency medical teams. "It's like being in the jungle rather than the zoo," said one speaker.

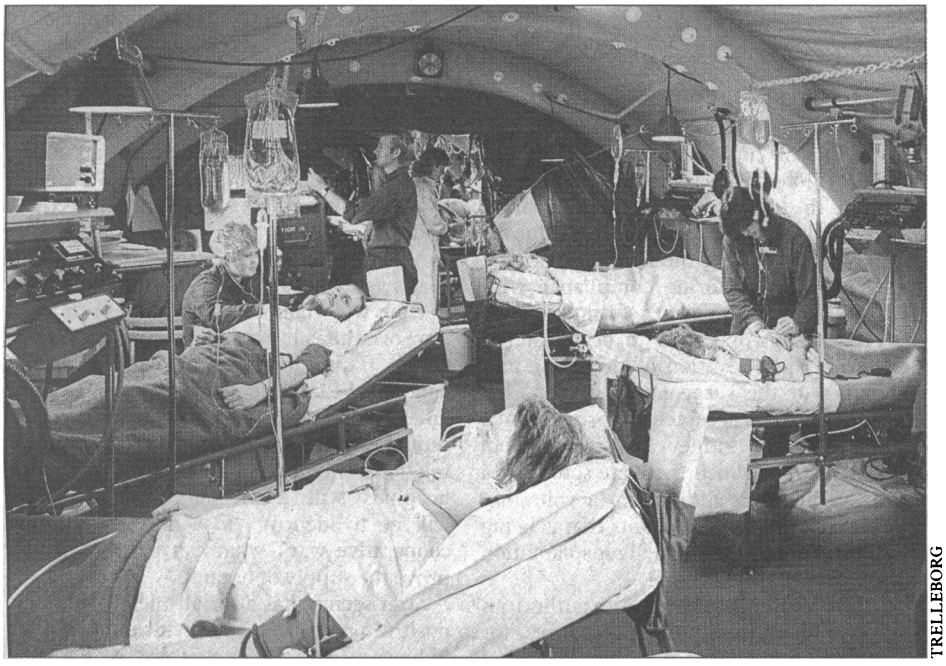
At disasters in Britain poor communication, coordination, and discipline, and sometimes inadequate triage and poor treatment and documentation at the site, were recurring themes. Important needs identified at the meeting were:

- An identifiable site medical officer, control point, and triage area
- Military style discipline in giving and taking orders
- More investment in equipment, including walkie-talkies, and identifiable and protective clothing
- A special "helpline" for inquirers, freeing hospital telephone lines
- More training of staff and testing of plans
- Standardisation of protocols (including the use of coloured triage labels)
- Early counselling and psychological follow up arranged nationally.

In Armenia the British medical teams had been too slow in arriving and therefore less effective than those from France, West Germany, and Austria because of problems in planning, coordination, and communication; one dialysis team, through no fault of its own, had arrived too late to treat any patients. Overseas disaster work, it was agreed, required urgent assessment of needs and immediate access to supplies and transport for swift coordinated delivery of items that were actually needed in the first few days and then careful planning for the intermediate (specialist) phase and for any long term help, such as the International Red Cross rehabilitation programme in Armenia for victims who sustained spinal injuries in the earthquake. Early helpers must take everything with them and beware of becoming a burden themselves.

Mr William Rutherford, now emergency planning adviser in Northern Ireland, argued that exercises had an important place in preparing for disasters. For example, "table top" exercises with models and details of the individual "casualties" have shown that standard triage theory and practice is now less applicable to the disasters in Britain than before; "talk through" exercises incorporating detailed preparatory work by members of the different services and outside experts may be applied to many different scenarios.

A ginger group, with Professor John Templeton (professor of traumatic orthopaedics at North Staffordshire Royal Infirmary) as its convenor, was set up as a means of improving the future response to disasters. It will define the medical problems and needs of rescue work nationally and internationally, helping the medical services to organise themselves. There was hope at the meeting that this group would approach the royal colleges to try to form a joint working group, which might then make formal recommendations to the government. The group will also liaise with the other services in its aim of evolving effective nationwide procedures and resources for tackling major incidents and obtaining the information and resources needed for the prompt dispatch of equipment and teams to disaster areas overseas—in this case, it was emphasised, with regular funding rather than ad hoc government aid and public donations.—DAPHNE GLOAG



TRELLEBORG

*Inflatable shelters are being used increasingly by ambulance services in large scale emergencies and can be used for advanced resuscitation as in this intensive care "ward" from the Swedish Field Hospital system*

# Community doctors criticise closure of food research establishment

By 14 June 18 cases of botulism had already been reported in the latest outbreak, so it was a particularly sensitive date for the government to announce the closure of the Food Research Establishment at Langford. The unit, employing 150 scientists, has close links with the University of Bristol and has been carrying out basic research on botulism and on the vertical transmission of salmonella in poultry (another subject with political implications).

The government wants such research to be financed by the food industry, but, as district medical officer Noel Olsen told the BMA's annual conference of community medicine and community health last week, the industry does not have a good track record on nutrition and health. In the past nine months outbreaks of food poisoning have occurred from salmonella in chicken and poultry products, and listeria in cheese and cook-chill food; the present health hazard is botulism associated with hazelnut puree in yoghurt. There is also a question mark over the safety of irradiated food.

The conference expressed grave concern at the closure decision. Anne McConville, a senior registrar in community medicine, declared that the decision was arbitrary, illogical, and against the interests of public health. The conference also expressed its dismay at the government's intention to reprieve unpasteurised non-human milk in England and Wales.

The motion condemning the closure at Langford was carried overwhelmingly, although one or two speakers had doubts about the uniqueness of the establishment. They suggested a rider, which was not carried, that any money withdrawn should be reallocated to the Public Health Laboratory Service to carry out similar work, but as Dr McConville pointed out the two organisations are quite separate and their functions do not overlap.—LINDA BEECHAM

# Kidneys not for sale

In a tetchy Commons which seeks to score political points over an outbreak of botulism the nearest thing to a non-partisan health topic in this session of parliament must be the Human Organ Transplants Bill. It completed its second reading and committee stage in two sittings by a special procedure that took it off the floor of the House. As a result it attracted zero attention despite having its origins in the kidneys for sale exposures at the beginning of the year (4 February, p 276).

It may turn out that the device of a short bill to deal with a special occurrence will have set back the prospects for more comprehensive legislation to advance the cause of organ transplants, as attention next year will be concentrated on the already delayed Warnock bill to regulate in vitro fertilisation and embryo research—possibly with abortion reform tacked on.

Even so, the emergency bill did produce a snapshot of parliamentary and government thinking on the subject of kidney donors and put down some hard markers for future progress that went beyond the immediate scope of the bill. Its main purpose is to tighten the controls to eliminate commercial trading in transplant surgery.

The legislation makes it a criminal offence to be concerned in payment for the supply of human organs for transplantation. Advertising such services will also be illegal. Any member of a hospital staff who knows that the law is being broken could also be prosecuted. The £2000 maximum fine envisaged is less relevant to doctors than the consequences for their career.

An Opposition attempt to lay a statutory duty on the General Medical Council to make trading in organs a disciplinary offence was withdrawn after a ministerial assurance that the GMC had expressed firm support for the bill and would deal "strongly, toughly, and promptly" with anyone who falls foul of its provisions. The bill, however, does not prevent the reimbursement of reasonable expenses incurred in the supply of transplant organs, including loss of earnings by living donors.

In addition, it prohibits use of transplants from living donors who are not genetically related to the patient—subject to important exemptions such as donations between spouses and from parents to their adopted children. A statutory authority of about a dozen members under a medical chairman will be appointed to vet the exemptions. Organs covered by the bill are defined as those that cannot be replicated by the body, though Labour fears of a "grisly trade" in bone marrow or gametes were answered by a promise that the use of regenerative tissue would be covered in forthcoming legislation.

Mr Roger Freeman, parliamentary under secretary for health, confirmed that there was no evidence of commercial dealings in transplants other than the cases that gave rise to the bill. In these it was alleged that Turkish men were admitted to the Humana Hospital Wellington through the auspices of the National Kidney Centre, a registered charity, for transplantation of kidneys to non-related recipients.

From Labour's front bench Miss Harriet Harman read into the record parts of unpublished reports by Barnet and Camberwell Health Authorities, though her versions were disputed by Mr Freeman. Miss Harman said that her intention was to ensure that the lessons are learnt about the relation between private medicine and markets for human organs. "In spite of this bill," she said, "the government's relentless promotion of private health care makes this more, not less, likely to happen in the future."

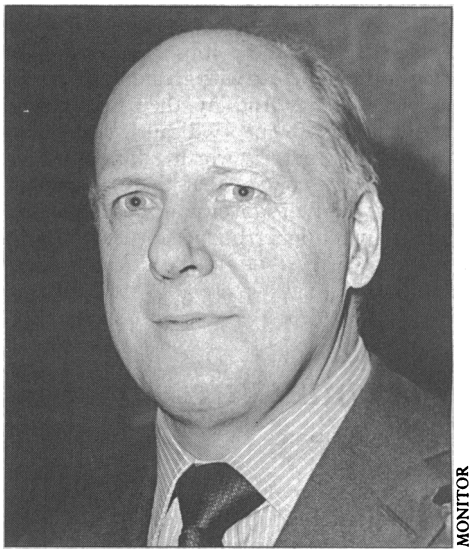
A first hand contribution to the debate came from Sir Michael McNair-Wilson, Conservative MP for Newbury, who has been receiving dialysis for five years and is awaiting kidney transplantation. He had been participating in a trial of the haemoglobin enhancing drug erythropoietin to counter the debilitating anaemia in such patients, a trial now successfully completed, he told me.

Sir Michael questioned the need for legislation at all if the medical profession could tighten up its ethics. He thought that the bill was negative and wanted something constructive from the Department of Health. His suggestion that donor cards could be countersigned by the next of kin, to avoid delay in seeking agreement from a relative before an organ is taken, was not debated. But he did secure an important promise from the government about how the bill will be policed by means of a register.

**Registers are necessary**

The minister agreed that some form of register in all hospitals, both NHS and private, will be necessary, and he is discussing with the profession what information should be placed on it. It would be the means not only of measuring the number of transplants but of monitoring compliance with the new law. Sir Michael's formula is for every transplant operation to be registered along with the derivation of the organ and the names of the surgeons concerned. Mr Freeman has so far accepted the principle of a register only for kidney transplants from living donors, of which there are some 200 a year. It will be in addition to a voluntary register covering all transplants that is being introduced by the British Transplantation Society from 1 July.

By the end of this month health authorities will have completed new procedures for identifying potential organ donors. First figures for 1988 show that there were 1544 NHS kidney transplants from patients who had died, to meet a waiting list of 3500. This year health authorities began an audit of potential donors among patients dying in intensive care. The results by the end of the year could transform the supply of organs for transplantation.



MONITOR

*Sir Michael McNair-Wilson, who has received dialysis for five years*

But as Sir Michael McNair-Wilson put it, the sale of a small number of organs shows that some people will not wait for parliament to dither. He added: "Those who want organs want them now because life is finite and they have no time to wait." Both he and Miss Harman pressed for statutory required request, with medical staff being obliged to ask relatives of dead patients to consider donating organs.

Mr Freeman thought that neither society nor the medical profession is yet able to accept mandatory required request, although he said that the government does not have a closed mind on the subject. If problems remained and the NHS could not get into a reasonable balance of supply and demand further steps would have to be considered, he said.

More encouragingly, the minister foreshadowed a Department of Health conference that he will chair in the autumn on how to improve the voluntary donation of cadaveric organs. This is to be a forum where all parties concerned can discuss what steps need to be taken. The agenda will cover such matters as required request, the donor card, and public relations. Mr Freeman hopes that private hospitals will participate. The objective will be to identify "in a non-partisan and cooperative way" what can be done to improve the supply of organs.

So it seems that after all there could be a positive outcome to the revulsion caused by kidneys for sale—a concept that Mr Freeman said is entirely unacceptable in a civilised society.—JOHN WARDEN